

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-030168

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7980

STATE FILE NUMBER

FILED AUG 15 1963

1. PLACE OF DEATH

a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo.

b. COUNTY

admission)

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. 8-4-63

c. CITY OR TOWN St. Louis,

Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hospital

Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 5459 Cologne

Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)

First Mary

Middle

Last Krah

4. DATE OF DEATH

Month August

Day 4

Year 1963

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 4/10/74

9. AGE (last birthday) 89

IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (City and state or country) St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME

Jacob Schenkel

13b. MOTHER'S MAIDEN NAME

Louisa Brandt

14. NAME OF HUSBAND OR WIFE

August Krah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) no

16. SOCIAL SECURITY NO.

17. INFORMANT Address Elizabeth Krah - 5459 Cologne

18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Arteriosclerotic Heart Disease

years

DUE TO (c)

+200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE ☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from June 12, 57 to August 4, 1963 and last saw him on August 4, 1963. Death occurred at 4:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

(Degree or title)

22b. ADDRESS

St. Louis Chronic Hospital

22c. DATE SIGNED

8/5/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

Aug. 7, 1963

23c. NAME OF CEMETERY OR CREMATORY

Park Lawn Cemetery

23d. LOCATION (City, town, or county)

St. Louis County, Missouri

24. FUNERAL DIRECTOR

ADDRESS

WACKER-HELDERLE-3634 Gravois Ave.

25. DATE RECD. BY LOCAL REG.

AUG 6 1963

26. REGISTRAR'S SIGNATURE

Boal Smith, M.D.

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Pharmaceuticals

Licensed Embalmer No. 4375  
P. O. Address St. Louis 14 Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.